

New Patient History



Name _____

Date of Birth _____

Birth History

Birth Weight _____

Hospital/City _____

Length of Stay _____

Problems _____

Past Hospitalizations

length of stay approx date or age

Reason _____

Reason _____

Reason _____

Past Surgeries

Medical Problems – please list below:

Does your child take any medications regularly?

Does your child have any allergies to medications? If yes, please list medication and reaction.

Who may we thank for your referral?

New Patient History

Has your child ever had the following:

- ___ Asthma/bronchitis/pneumonia
- ___ Frequent ear infections
- ___ Heart problems/murmurs
- ___ Seizure
- ___ Loss of consciousness or head injury
- ___ Bladder or kidney infection
- ___ Broken bones (age or date _____)

Does anyone in the immediate family have the following:

- ___ Asthma or frequent bronchitis
- ___ Severe allergies
- ___ Heart problems (< 50 yrs of age)
- ___ Juvenile or Insulin Dependent Diabetes
- ___ Seizures of other neurologic disorders
- ___ Malignancy or cancer
- ___ Thyroid disorder
- ___ Depression or psychiatric disorder
- ___ Attention Deficit Disorder or learning disorders
- ___ Kidney disorders
- ___ Stomach or bowel disorders

Tell us about your home:

Adults

Relationship to child and place of employment

Siblings and age

Number of smokers: _____

Pets

Indoor: _____

Outdoor: _____

Patient Name _____

Date of Birth _____

and secondary home if applicable:

City/State: _____

Adults

Relationship to child and place of employment

Siblings and age

Number of smokers: _____

Pets:

Indoor: _____

Outdoor: _____

Signature of person filling out this form.
